Supreme Court, U.S.
FILED

961167 JAN 17 1997

No. OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1996

SWARAN KUMAR JAIN,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR A WRIT OF CERTIORARI

JEAN PAUL BRADSHAW II
Counsel of Record

CHARLES J. WILLIAMS
LATHROP & GAGE L.C.
2345 Grand Blvd., Suite 2500
Kansas City, MO 64108-2684
(816) 292-2000
Counsel for Petitioner

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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QUESTION PRESENTED

What is the scienter requirement for "knowingly and willfully" paying or receiving remuneration in exchange for referring patients, in violation of the Medicare Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), as to which question courts of appeal, district courts, and the Departments of Health and Human Services and Justice are all in conflict?

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PETITION FOR A WRIT OF CERTIORARI

Dr. Swaran K. Jain respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (*infra*, App. 1-15) is reported at 93 F.3d 436. The opinion of the district court (*infra*, App. 16-26) is not reported.

JURISDICTION

The court of appeals entered its judgment on August 8, 1996 (*infra*, App. 1). The court of appeals denied cross petitions for rehearing on October 22, 1996 (*infra*, App. 16-26). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

The Medicare-Medicaid Anti-Fraud and Abuse Amendments, 42 U.S.C. § 1320a-7b(b)(1)(A), provides in pertinent part:

> (b) Illegal remunerations
>
> (1) whoever knowingly and willfully solicits or receives any remuneration (including

any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind –

> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program,
>
> * * * *

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

STATEMENT

On May 24, 1994, a federal grand jury returned an indictment against Petitioner, charging him in 19 counts with committing various crimes, including a violation of the Medicare Fraud Act. R.1, Indictment.[1] The Government brought these criminal charges against Petitioner, a psychologist, because of his financial relationship with a psychiatric hospital. The Government alleged Petitioner

[1] The Medicare-Medicaid Anti-Fraud and Abuse amendments will be referred to throughout as the "Medicare Fraud Act" for ease of reference. In addition to the Medicare Fraud Act count, the Indictment charged Petitioner with conspiracy to commit an offense against, and to defraud, the United States, in violation of 18 U.S.C. § 317, bribery in violation of 18 U.S.C. § 666, and 16 counts of mail fraud in violation of 18 U.S.C. §§ 1341, 1346. Record cites herein refer to the record before the Eighth Circuit Court of Appeals.

"knowingly and willfully" solicited and received payments from the hospital in exchange for referring patients to the hospital. The Petitioner denied the charges, asserting the payments he received were in exchange for legitimate services he performed for the hospital.

A. Statement of Facts

Petitioner Dr. Jain practiced psychology in his private clinic, the Center for Mental Health Services, which he started in 1985 in Leavenworth, Kansas. VI Tr. 1137, 1141-42. Over a five-year period Dr. Jain built a successful practice in his community, employing as many as fifteen psychologists and counselors on either a full-or part-time basis. VI Tr. 1263-64.

In 1988, North Hills Psychiatric Hospital ("North Hills") opened in nearby North Kansas City, Missouri. II Tr. 57-58. It was the only exclusively psychiatric hospital located near Dr. Jain's clinic. II Tr. 131-33; VI Tr. 1165. Dr. Jain began referring patients to North Hills in January, 1989.

As a new facility, North Hills sought to establish relationships with mental health professionals in the area and to increase the public awareness of psychiatric care generally and of the hospital specifically. VI Tr. 1165, 1169-72, 1174. Tom Trenary, North Hills' first administrator, called on Dr. Jain in the spring of 1989. II Tr. 66-67, 75. As a result of their meeting, North Hills agreed to pay Dr. Jain $1,000 per month in return for marketing services and, according to Trenary, referring patients to North Hills. II Tr. 74-75. Dr. Jain received the first payment in

July, 1989. Pursuant to his duties to North Hills, during the remainder of 1989 and during 1990 Dr. Jain conducted seminars in conjunction with North Hills, evaluated children at a North Hills-sponsored KidsQuest program, and attended meetings and met with educators in an effort to increase community awareness of mental health problems and treatment options.

Gary Boillotat replaced Trenary as administrator of North Hills in November, 1989.[2] II Tr. 62, 145, 152. Boillotat continued the business relationship with Dr. Jain, increasing the amount of the monthly payments at Dr. Jain's request, because Dr. Jain claimed he was doing more work and allegedly for referring more patients to North Hills. II Tr. 167-68, 170, 179-80, 194, 246. When a new administrator replaced Boillotat in the fall of 1990, the business relationship with Dr. Jain terminated, though Dr. Jain continued to refer patients to North Hills through June, 1992, some two years later. VI Tr. 1253-54, 1259-61. In all, Dr. Jain referred 61 patients to North Hills, only one of whom happened to be insured by Medicare. R. 1 Indictment, p. 17.

The patients Dr. Jain referred to North Hills needed to be hospitalized and North Hills provided appropriate services for them. II Tr. 129-30; III Tr. 353, 379-81; IV Tr. 659-60, 665-66, 679-80. The Government, in fact, conceded this point and the district court instructed the jury that "For purposes of this case, the jury is entitled to believe

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[2] Both Trenary and Boillotat testified pursuant to plea agreements with the Government whereby Trenary was granted immunity and Boillotat pleaded guilty to a misdemeanor. II Tr. 127-29, 233-36.

that all of the sixty some odd patients needed hospitalization and they were properly hospitalized." III Tr. 381.

B. Proceedings Below

Before trial, Dr. Jain filed a motion to dismiss all but the Medicare Fraud Act charge against him, which motion was denied. Following the presentation of the evidence, the district court dismissed that portion of the conspiracy charge alleging a conspiracy to defraud the United States. VI Tr. 1346. With regard to the word "willfully" as used in the Medicare Fraud Act, the district court instructed the jury that it means "unjustifiably and wrongfully, known to be such by the defendant Swaran Jain." R. 72 Instruction M. The district court rejected Dr. Jain's request that the jury be instructed that to find Dr. Jain "willfully" violated the statute, the Government must prove he "voluntarily and intentionally violated a known legal duty." VII Tr. 1382-86. The district court acknowledged its definition of willfully "would contemplate an ethical violation" (VII Tr. 1383) and if it adopted Dr. Jain's request, "there probably is no submissible case on 'willfully'. . . . " VI Tr. 1363.

After instruction and a day and a half of deliberation, the jury returned a guilty verdict against Dr. Jain on all remaining charges. VII Tr. 1510-11; R. 70 Verdict; R. 71 Verdict. These consisted of one count of conspiracy, one bribery count, sixteen mail fraud counts, and the Medicare Fraud Act count.

Dr. Jain thereafter filed a Motion for Judgment of Acquittal, or in the Alternative, for a New Trial, pursuant to Rules 29 and 33, Federal Rules of Criminal Procedure,

with respect to all counts. R. 78 Motion. He also filed a Motion for Arrest of Judgment pursuant to Rule 34, with respect to a portion of the conspiracy count, the bribery count, and the mail fraud counts. R. 77 Motion. The district court vacated the conviction on the conspiracy count, gave a judgment of acquittal on the bribery count, but denied the motions with respect to the Mail Fraud counts and the Medicare Fraud Act count. R. 92 Memorandum and Order; *infra*, App. 16-26. The district court sentenced Dr. Jain on July 6, 1995, to a five-year sentence of probation (with a condition he serve six months of home confinement) and a $10,000 fine. R. 108 Judgment. The district court suspended imposition of the sentence pending appeal. *Id.*

On July 12, 1995, Dr. Jain filed a timely Notice of Appeal to the Eighth Circuit Court of Appeals. R. 110 Notice of Appeal. On appeal, Dr. Jain sought reversal of the mail fraud convictions on the ground the Government failed to show any harm to anyone. Dr. Jain sought reversal of the Medicare Fraud Act conviction on the ground the district court improperly instructed the jury on the *mens rea* standard. Specifically with respect to the Medicare Fraud Act conviction, Dr. Jain asserted the district court should have instructed the jury using a *Ratzlaf* standard, based on the decision in *Ratzlaf v. United States*, 510 U.S. 135 (1994). *Ratzlaf* was a currency structuring case in which this Court held that to obtain a conviction for "willfully" structuring deposits, the Government must prove a defendant "acted with knowledge that his conduct was unlawful." 510 U.S. at 137.

On August 8, 1996, the court of appeals issued its opinion, reversing the convictions on the mail fraud

charges, but affirming the Medicare Fraud Act conviction. *United States v. Jain*, 93 F.3d 436 (8th Cir. 1996), *infra*, App. 1-15. Based on its review of the legislative history of the Medicare Fraud Act and the regulatory context of the health care industry, the Eighth Circuit agreed the Medicare Fraud Act required a heightened scienter requirement. 93 F.3d at 440. It concluded, however, the district court's instruction was sufficient and a *Ratzlaf*-type instruction was unnecessary. 93 F.3d at 441. It specifically rejected the Ninth Circuit's application of the *Ratzlaf* standard to the Medicare Fraud Act in *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995), on the grounds the *Hanlester* case involved an administrative disbarment proceeding and because it concluded the Ninth Circuit adopted the *Ratzlaf* standard "without considering other alternatives to the general rule." *Id.*

Dr. Jain filed a timely petition for rehearing on August 22, 1996. The court of appeals invited the Government to respond, which it did on September 17, 1996. After receiving several extensions of time, the Government itself filed an untimely petition for rehearing on October 9, 1996. The court of appeals denied both petitions for rehearing on October 22, 1996. *Infra*, App. 27.

REASONS FOR GRANTING THE PETITION

This Court should grant certiorari to resolve the conflict between the Eighth Circuit's decision in *United States v. Jain*, 93 F.3d 436 (8th Cir. 1996), and the Ninth Circuit's decision in *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995), in the construction of the Medicare Fraud Act.

See McElroy v. United States, 455 U.S. 642, 643 (1982) (certiorari granted because of "a conflict among the Circuits on this issue of statutory construction"). In addition, district courts are entering decisions and instructing juries on the scienter requirement in ways that conflict with both *Hanlester* and the Eighth Circuit's decision in this case, further calling for the granting of certiorari. *See Heffron v. International Soc'y for Krishna Consciousness, Inc.*, 452 U.S. 640, 646 (1981) (certiorari granted because of conflicts in lower court decisions, citing *inter alia* district court decisions). Finally, the Department of Health and Human Resources ("HHS") has adopted a scienter standard for its administration of the Medicare Fraud Act that is consistent with *Hanlester* but conflicts with the standard advocated to courts by the Department of Justice. This conflict of view between federal agencies regarding the enforcement of a federal criminal law further militates in favor of granting certiorari. *See United States ex rel. Chapman v. Federal Power Comm'n*, 345 U.S. 153, 155 (1953) (certiorari granted because of "conflict of view between two agencies of the [federal] Government").

In *United States v. Jain*, the Eighth Circuit Court of Appeals erred in sanctioning the district court's *ad hoc* formulation of a scienter requirement under the Medicare Fraud Act instead of following the *Hanlester* decision. The Eighth Circuit found a heightened scienter requirement necessary because of the Congressional intent reflected in the Medicare Fraud Act's legislative history and because the Act's broad and vague language creates a danger of entrapping health care professionals who lack criminal intent. This same finding was the basis for this Court's decision in *Ratzlaf*, as the *Hanlester* Court recognized.

Nevertheless, the Eighth Circuit approved the district court's unique jury instruction which incorporates state ethical rules into the scienter requirement under the Medicare Fraud Act.

This case presents a critical issue for review. The Attorney General of the United States has declared health care fraud the number one priority of the Department of Justice after violent crime. One of the Government's primary weapons is the Medicare Fraud Act. Health care professionals are confronted with the threat of criminal prosecution under a statute which poses a serious danger of entrapping health care professionals who lack criminal intent. A heightened scienter requirement like the one this Court adopted in *Ratzlaf* is necessary to ensure that only those who act with criminal intent are punished criminally. A heightened scienter requirement is the most effective way of preventing federal entanglement in state ethical rules governing health care professionals. The lower courts, prosecutors, and health care professionals are in dire need of a clear standard and guidance which this Court alone can provide.

I. The Eighth Circuit's Scienter Standard for the Medicare Fraud Act Conflicts With the Ninth Circuit's Standard and Aggravates an Existing Split of Authority in the District Courts and Between the Departments of Health and Human Services and Justice

Conflict exists at many levels regarding the appropriate scienter requirement under the Medicare Fraud Act (the "Act"). Two federal courts of appeal have issued directly conflicting opinions. District courts are in conflict

with each other and with the courts of appeals. There is even conflict in the same branch of Government between the standard adopted by HHS and that pursued by the Department of Justice. Guidance is needed from this Court to resolve these conflicts, especially because resolution of this issue determines whether health care professionals will go to prison. Due process and fundamental fairness demand that criminal laws be sufficiently certain so as to allow people the opportunity to conform their behavior to avoid criminal sanctions. *Posters 'N' Things, Ltd. v. United States*, 114 S. Ct. 1747, 1754 (1994).

A. Conflict Exists Between Courts of Appeal

In *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995), the Ninth Circuit Court of Appeals held that the Medicare Fraud Act requires a heightened scienter standard. In *Hanlester* the Government brought a disbarment action against a health care partnership seeking to bar the partnership from the Medicare and state health care programs because the partnership allegedly violated the Medicare Fraud Act.[3] 51 F.3d at 1395. The Government alleged the partnership violated the Medicare Fraud Act by "offering and paying remuneration to physician-investors to induce them to refer laboratory tests" to partnership-owned laboratories. *Id.* A central issue in the case was the scienter requirement imposed under the Medicare Fraud Act. In resolving this issue, the *Hanlester*

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[3] A civil disbarment proceeding is commonly referred to as a "civil death penalty" in the health care industry because disbarment effectively destroys a company.

Court expressly adopted the standard this Court announced in *Ratzlaf v. United States*, 510 U.S. 135, 149 (1994), holding: "We construe 'knowingly and willfully' in . . . the anti-kickback statute as requiring appellants to (1) know that [the anti-kickback statute] prohibits offering or paying remuneration to induce referrals, and (2) engage in prohibited conduct with the specific intent to disobey the law." 51 F.3d at 1400.

In *Ratzlaf*, this Court found the term "willfulness" requires both knowledge of the law and the specific intent to commit the crime. The Government prosecuted Ratzlaf for structuring financial transactions to avoid currency reporting requirements under the anti-structuring provisions of the Money Laundering Control Act of 1986, 31 U.S.C. § 5324. The district court instructed the jury that the Government had to prove the defendant's knowledge of the bank's reporting requirements and his attempt to evade those requirements, but did not have to prove the defendant knew the structuring was unlawful. 510 U.S. at 137. Ratzlaf was convicted and the Ninth Circuit upheld his conviction. *Id.* This Court reversed. After reviewing the legislative history of the Act and the complex provisions in which the criminal sanctions were embedded, this Court found the Act required a heightened *mens rea* requirement so as not to ensnare those who structured transactions without a criminal intent. 510 U.S. at 137-38. Accordingly, this Court held that "the Government must prove that the defendant acted with knowledge that his conduct was unlawful." 510 U.S. at 137.

In adopting this Court's *Ratzlaf* standard, the *Hanlester* Court clearly shared this Court's concern about the danger of ensnaring innocent people within the net of a

broad criminal statute. The Ninth Circuit therefore concluded that this Court's definition of "willfulness" announced in *Ratzlaf* was the proper definition for the same term as used in the Medicare Fraud Act. The *Hanlester* Court correctly decided that a heightened scienter requirement was the only way to ensure criminal sanctions would be brought to bear on defendants who had an evil intent, and not on health care professionals whose actions some might consider improper, but who lacked a criminal intent.

In *United States v. Jain*, 93 F.3d 436 (8th Cir. 1996), the Eighth Circuit was presented with the same issue: the proper *mens rea* standard under the Medicare Fraud Act. Like the Ninth Circuit, the Eighth Circuit recognized the danger of ensnaring innocent people with this criminal statute. 93 F.3d at 440. Further, the court agreed a heightened scienter requirement was necessary under the Act because the literal language of the Act may encompass "conduct that is not 'inevitably nefarious.' " 93 F.3d at 440 (quoting *Ratzlaf*, 510 U.S. at 144). Nevertheless, the Eighth Circuit summarily rejected the *Hanlester* decision on the grounds that "it involved an administrative debarment proceeding" and based on the court's assumption that the Ninth Circuit did not consider other options (presumably referring to the district court's *ad hoc* instruction as an option). 93 F.3d at 441. Despite the civil status of the *Hanlester* case, however, the proceedings were based upon an alleged violation of the identical provision of the Medicare Fraud Act at issue in *Jain*. Further, the Eighth Circuit's assumption that the Ninth Circuit failed to consider any other option is both speculative and irrelevant so long as the Ninth Circuit was correct.

Instead of following the Ninth Circuit and applying the *Ratzlaf* standard to the Medicare Fraud Act, the Eighth Circuit found the district court's *ad hoc* jury instruction, defining "willfully" as "unjustifiably and wrongfully, known to be such by the defendant Swaran Jain," was sufficient. 93 F.3d at 441. No other court has ever used such a definition of willfully. Furthermore, the district court based its instruction in part on the Government's theory that a violation of state ethical rules is sufficient to show a violation of the Medicare Fraud Act. VII Tr. 1383 (district court acknowledged that its definition of "willfully" "would contemplate an ethical violation" and that there probably was not a submissible case if the court adopted the requested *Ratzlaf* standard). The district court's use of the words "unjustifiably and wrongfully" enabled the jury to find Dr. Jain guilty so long as it believed he knew his behavior was unethical, without knowing that it was unlawful. The Eighth Circuit's decision approving this instruction allows the mere knowledge that one is violating a state ethical rule to satisfy the *mens rea* element of the Medicare Fraud Act. This unprecedented ruling directly conflicts with the Ninth Circuit's approach and invites future conflicts as other circuits similarly attempt to reconcile conflicting state ethical standards with the *mens rea* element of the Medicare Fraud Act.

In addition to the holdings in *Hanlester* and *Jain*, one other appellate court has addressed the *mens rea* standard under the Medicare Fraud Act. In *United States v. Bay State Ambulance & Hosp. Rental Serv., Inc.*, 874 F.2d 20, 23-26 (1st Cir. 1989), the defendants were convicted of

violating the Medicare Fraud Act when they paid remuneration to a city employee in order to secure a contract for providing emergency ambulance service for the city. On appeal of their convictions, the defendants raised an objection to the district court's jury instruction on the *mens rea* element. 874 F.2d at 33. The district court had instructed the jury that: "Willfully means to do something purposely, with the intent to violate the law, to do something purposely that law forbids." *Id.* Evaluating the instruction for plain error (since the defendants failed to object to the instruction at trial), the First Circuit found the instruction "appropriate" and not in error. *Id.* This language is similar to that adopted by the *Hanlester* court. Indeed, the *Hanlester* court cites the *Bay State* decision in its opinion and clearly had it in mind in reaching its holding. *Hanlester*, 51 F.3d at 1397.

B. Conflict Exists at the District Court Level

Obviously the district courts have been the first to wrestle with the problem of determining the appropriate scienter requirement under the Medicare Fraud Act. Only two reported district court decisions have specifically addressed this issue, however, and they are in conflict with each other and the courts of appeal. In *United States v. Neufeld*, 908 F. Supp. 491, 497 (S.D. Ohio 1995), the court denied the defendant's motion to dismiss the Medicare Fraud Act charge on a vagueness challenge, specifically rejecting the *Hanlester* approach to the scienter issue and holding that a "formulation of 'willful' which takes into account the purpose to commit a wrongful act is sufficient to eliminate the vagueness challenge." 908 F.

Supp. at 497 (citing district court decision in *United States v. Jain* as authority). The court was careful to note it was not adopting "an exact definition of the scienter requirement at this time." *Id.*[4]

In contrast, in *Modern Medical Lab., Inc. v. Smith-Kline Beecham Clinical Lab., Inc.*, No. 92 C5302, 1994 WL 449281 at *4 (N.D. Ill. Aug. 17, 1994), the court implied that the term "willfully" as used in the Medicare Fraud Act requires a showing of intent to violate the law. In this case Modern Medical Laboratories, Inc. ("MML") sued Smith-Kline Beecham Clinical Laboratories, Inc. ("Smith-Kline") for breach of contract. The contract provided that International Clinical Laboratories ("ICL") (a company later purchased by Smith-Kline) would market, manage, and operate MML's laboratory business in exchange for 90% of the revenue. *Id.* at *1. When Smith-Kline took over ICL, it advised MML that it would not make further payments under the Agreement because it believed the payments were illegal under the Medicare Fraud Act. *Id.* In determining that the Agreement was unenforceable, the district court held that:

> [T]he Agreement had all of the elements of being violative of the Act, except the scienter element may or may not have been present. However, performance of the contract after this ruling would definitely constitute a knowing and willful violation and thus, future performance would be illegal.

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[4] The *Neufeld* district court never gave final jury instructions to the jury on the scienter issue or any other issue, however, because the court declared a mistrial on the first day of trial.

Id. at *4. Accordingly, while the district court never directly ruled on the scienter requirement under the Medicare Fraud Act, it did conclude that knowledge that an agreement was illegal was sufficient to demonstrate a willful violation of the Act.

C. Conflict Exists Among Agencies of the Executive Branch

The Department of Justice urged the district court below to instruct the jury that the word "willfully" in the Medicare Fraud Act means to voluntarily commit the act in question. According to the Department of Justice position, the Government need make no showing the defendant had any idea the act he was committing was prohibited by law. Across the Washington Mall, however, the Department of Health & Human Services ("HHS") has promulgated instructions to its criminal investigators giving the opposite definition of willfully.

The Health Care Financing Administration (HCFA), a part of HHS, is the federal agency primarily responsible for administering the Medicare and Medicaid programs. In its Regional Office Manual, HCFA defines certain terms used in the criminal provisions of the Medicare Fraud Act. The definitions are included as part of the manual intended to instruct criminal investigators what the law requires in order to support a conviction under the Medicare Fraud Act.

Among the defined terms is "willfully," which HCFA defines as requiring actual knowledge of the existence "of a legal obligation and the intent to evade that obligation"

and a showing that the person acted "voluntarily, purposefully, deliberately, and intentionally as opposed to accidentally, inadvertently, or carelessly." HCFA Regional Office Manual, R02, § 4204D, CCH Medicare and Medicaid ¶ 13,915.17. This definition of willfulness follows the *Hanlester* decision, but is in conflict with the Eighth Circuit's decision in *Jain*. The scienter standard the Department of Justice is urging on district courts, of course, conflicts with *Hanlester*, *Jain* and HHS.

II. The Eighth Circuit's Decision in *United States v. Jain* is Erroneous

The proper scienter standard under the Medicare Fraud Act should require the Government to prove the defendant knew the act he committed was against the law and that he committed the act with the specific intent to violate the law. Two compelling factors mandate this result. First, the regulatory scheme surrounding business relationships and patient referrals in the health care industry is so complex and confusing that the highest scienter requirement is necessary to prevent the criminal prosecution of health care professionals who lack a "criminal" intent, yet who may inadvertently violate the law. Second, the legislative history of the Medicare Fraud Act reflects a Congressional intent to impose a heightened scienter requirement precisely to prevent the imposition of criminal sanctions upon health care professionals who lack a specific intent to break the law.

A. The Complex Regulatory Scheme Requires a Strict Scienter Standard

While ignorance of the law usually is no excuse, it may constitute a defense in cases involving criminal statutes under complex regulatory schemes that have the potential of ensnaring unintentional violators. *United States v. Fierros*, 692 F.2d 1291, 1295 (9th Cir. 1982), *cert. denied*, 462 U.S. 1120 (1983). Election campaign laws, tax laws, banking laws, and export laws are all examples of areas subject to complex regulatory schemes where the courts have required the Government to prove an intentional violation of the law.[5] The regulatory scheme encompassing the Medicare Fraud Act rivals, indeed surpasses, these areas in complexity.

The Medicare Fraud Act is part of a complicated regulatory scheme governed by the Secretary of HHS. This scheme is so complex, however, that from the very beginning HHS itself exhibited uncertainty regarding the precise legality of payments to doctors from hospitals. In 1987, Congress instructed HHS to establish certain "safe harbor" regulations to clarify which payments from hospitals to doctors the Government would deem lawful and

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[5] *See, e.g., Ratzlaf*, 510 U.S. 149 (currency structuring law requires proof defendant acted with knowledge his conduct was unlawful); *Cheek v. United States*, 498 U.S. 192, 201-202 (1991) (tax prosecution requires proof of violation of known legal duty); *United States v. Curran*, 20 F.3d 560, 568-69 (3d Cir. 1994) (applying *Ratzlaf* willfulness standard by analogy in prosecution under disclosure requirements of Election Campaign Act); *United States v. Lizarraga-Lizarraga*, 541 F.2d 826, 829 (9th Cir. 1976) (Government required to show defendant knew export of product specifically violated export laws).

which it would consider unlawful under the Medicare Fraud Act. 42 U.S.C. § 1320a-7b(b)(3)(E). Its own uncertainty about how to regulate these payments, however, prevented HHS from adopting the initial regulations until 1991. The original safe harbor regulations quickly proved inadequate, leading HHS to re-promulgate safe harbor regulations repeatedly over the past five years.[6] A decade after Congress instructed HHS to clarify the law, exactly which payments to doctors from hospitals under what conditions are legal, and which are illegal, continues to be highly debatable.

"It is settled that when the law is . . . highly debatable, a defendant – actually or imputedly – lacks the requisite intent to violate it." *United States v. Critzer*, 498 F.2d 1160, 1162 (4th Cir. 1974). This principle applies to the Medicare Fraud Act. When instructing the Secretary of HHS to create safe harbor regulations, Congress recognized the breadth of the language of the Medicare Fraud Act "has created uncertainty among health care providers as to which commercial arrangements are legitimate, and which are proscribed." Medicare and Medicaid Patient and Program Protection Act of 1987, S. Rep. No. 100-109,

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[6] HHS issued the initial safe harbor regulations in 1991. 56 Fed. Reg. 35952 (July 29, 1991). In 1993 the HHS Inspector General proposed seven new regulations identifying payments which, "although potentially capable of inducing referrals of business under the Medicare and State health care programs, would not be treated as criminal offenses." 58 Fed. Reg. 49008 (Sept. 21, 1993). In 1994 the Inspector General issued yet another proposed rule to clarify "ambiguities that have created uncertainties for health care providers trying to comply with the safe harbor provisions." 59 Fed. Reg. 37202, 37203 (July 21, 1994).

100th Cong. 1st Sess. 27, at 27, *reprinted in* 1987 U.S.C.C.A.N. 682, 707. The safe harbor regulations have not solved the problem, but rather have exacerbated the problem by creating a quagmire of regulatory complexity making it nigh impossible for a health care professional to know what is illegal. Ultimately the legality of a financial arrangement may turn solely upon the health care professional's intent. Accordingly, to hold a health care professional criminally liable, the Government should bear the burden of proving an intentional violation of the law which the Government itself has made so complex.

B. Congress Intended a Strict Scienter Requirement

One of the principal reasons this Court established the strict scienter standard in *Ratzlaf* was because it found Congress intended the currency str ıcturing statute to have a heightened scienter requirement. *Ratzlaf*, 510 U.S. at 140-44. The legislative history of the Medicare Fraud Act similarly reflects a Congressional intent to impose a heightened scienter standard. In 1980 Congress amended the Medicare Fraud Act, adding language requiring the offense of paying or accepting a referral fee be committed "knowingly and willfully" in order to prevent the conviction of improper but unintended conduct. *See* Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599 (1980), *codified at* 42 U.S.C. § 1395nn(b)(1). Congress was "concerned that criminal penalties may be imposed under current law to an individual whose conduct, while

improper, was inadvertent. Accordingly the section clarifies current law to insure that only persons who knowingly and willfully engage in proscribed conduct could be subject to criminal sanctions." Omnibus Reconciliation Act of 1980, H.R. Rep. No. 96-1167, 96th Cong., 2d Sess. 59, *reprinted in* 1980 U.S.C.C.A.N. 55260, 55762 (1990). This is similar to the intent Congress expressed with regard to the structuring statute at issue in *Ratzlaf*, upon which this Court based its decision requiring a showing that the defendant acted with the specific intent to violate the law.

Accordingly, the Eighth Circuit erred when it rejected the *Ratzlaf* and *Hanlester* scienter standard and instead approved the district court's improvised instruction. This Court needs to establish a scienter standard sufficient to provide adequate notice to health care professionals. The Eighth Circuit's approval of a district court's *ad hoc* creation of a new scienter standard invites a confusing array of standards among the circuits. Such an approach provides no predictability and therefore makes it impossible for health care professionals to conform their behavior to comply with the law.

III. The Question Presented is Important

The executive branch of the federal government has embarked on an ever-growing, but ill-defined, program of expanding federal criminal jurisdiction into areas traditionally under the control of the states. *See generally* Roger J. Miner, *Federal Courts, Federal Crimes, and Federalism*, 10 Harv. J.L. & Pub. Pol'y 117 (1987). The latest field of expansion is the health care industry. Responding to a

perceived crisis in health care, the Government has unleashed agents and prosecutors with the charge of rooting out health care fraud, as if that will alone resolve the crisis. The Attorney General has established the prosecution of health care fraud as the number one priority of the Department of Justice after violent crime. United States Attorneys across the country have formed health care fraud units and task forces to back up this effort. Federal prosecutions of health care fraud have increased more than 200 percent since 1992. *Prevention of Corporate Liability*, Vol. 4, No. 9, at p.4 (BNA Oct. 21, 1996).

The problem with trying to reduce health care fraud with broad criminal statutes, however, lies in the complexity of the health care industry itself. The industry evolved over a long period of time, shaped by market, regulatory, and humanitarian forces into a unique and perplexing labyrinth of complicated interrelationships. Yet, it still remains part of the free market enterprise system. Hospitals, clinics, doctors, laboratories, billing companies and others have for many years engaged in wholly legitimate financial relationships with each other. Money changes hands between these parties constantly pursuant to a whole series of interrelated obligations. Simultaneously, the parties refer patients and services to each other. While reform may be necessary to eliminate or control these interdependent financial arrangements, the Government has actually exacerbated the problem with threats of criminal sanctions.

The states historically have assumed the primary responsibility to regulate their own health care professionals. Doctors are licensed by states, not by the federal government. Thus, health care professionals traditionally

have been governed in their business practices by ethical rules imposed by the states in which they practice. Ethical rules provide guidance in the midst of complexity. Ethical rules also provide flexibility the criminal law does not.

The federal government has now stepped into this arena using criminal statutes to address historically state-controlled ethical issues. Basing federal jurisdiction on the source of the insurance payment, or any other basis available, the Government is using heavy weapons against a dispersed and limited number of allegedly fraudulent individuals. One of the Government's principal weapons is the Medicare Fraud Act, the scope of which not even HHS itself seems to understand. Health care professionals are therefore caught in a minefield. Unsure of which financial relationships are permitted and which are not, they struggle to provide medical care within a complex health care industry, unsure whether the next step they take could subject them to federal criminal charges. Their actions are no longer governed by their state-based ethical rules and the desire to provide health care. Now fear of imprisonment chills their behavior and impinges upon the exercise of their professional judgment.

Further, the Government's prosecution of health care professionals threatens federalism principles when it is based upon alleged violations of state ethical rules. In *Jain*, the Government relied heavily on state ethical rules as a basis for convincing the jury that Dr. Jain's actions were "wrong." At the Government's behest, the district court even adopted a definition of "willfulness" that it acknowledged encompassed unethical conduct. In effect, the Government criminalized state ethical rules. Such

overreaching by the Government encroaches upon and threatens a state's right to establish standards for and govern the action of professionals licensed by the state. To allow the Government to criminalize state ethical rules is to allow the federal Government to supplant the states in determining acceptable behavior by state-licensed professionals. A *mens rea* standard devoid of reliance on ethical concepts of "justifiably and wrongfully" and based on a Government showing of intentional violation of the criminal law will preserve the federal/state balance.

This Court's guidance is needed to delineate the scope of the Medicare Fraud Act. Health care professionals need to know whether they can be held criminally liable even when they lack the intent to violate the law. The ramifications are significant. The resolution of this problem is far-reaching; it affects the way in which health care professionals practice medicine nationwide. Adoption of the scienter standard which the Department of Justice urges upon the courts will lead to a deterioration of the quality of health care provided because health care professionals will make decisions based on fear of criminal sanctions instead of concern for the patient's care. Adoption of the standard advocated by Petitioner gives reassurance to health care professionals that only those who intentionally violate the law will be held criminally liable, releasing the constraints on the free market health care system and allowing health care professionals to do what they do best – treat patients.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

JEAN PAUL BRADSHAW II
Counsel of Record
CHARLES J. WILLIAMS
LATHROP & GAGE L.C.
2345 Grand Blvd., Suite 2500
Kansas City, MO 64108-2684
(816) 292-2000
Counsel for Petitioner

United States of America, Plaintiff - Appellee/Cross Appellant, v. Swaran Kumar Jain; Center for Mental Health Services, Inc., Defendants - Appellants/Cross Appellees.

No. 95-2820, No. 95-3036

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

April 11, 1996, Submitted
August 8, 1996, Filed

Jean Paul Bradshaw, Kansas City, Missouri argued (Charles J. Williams, on the brief), for appellants/cross-appellees.

Linda L. Parker, Kansas City, Missouri, argued (Stephen L. Hill, Jr., United States Attorney, on the brief) for appellee/cross-appellant.

Psychologist Swaran Kumar Jain and his corporation, the Center for Mental Health Services, Inc., appeal their convictions for violating the mail fraud and Medicare anti-kickback statutes by receiving payments from a psychiatric hospital for referring patients to that hospital. Defendants argue that the district court's jury instructions erroneously defined the term "willfully" in the anti-kickback statute, and that the government failed to prove mail fraud, that is, a scheme to deprive Dr. Jain's patients of their intangible right to his "honest services." The government cross-appeals, contending that the district court erred in determining the improper benefit conferred by the kickbacks for purposes of sentencing Dr. Jain under U.S.S.G. § 2B4.1(b)(1). We reverse the convictions for mail fraud but otherwise affirm.

I. Background.

We must view the evidence in the light most favorable to the jury's verdict. The government's key witnesses were two former administrators of North Hills Hospital ("North Hills"), an acute-care psychiatric hospital which opened in Kansas City, Missouri, in 1988. Dr. Jain was then a psychologist in private practice in Leavenworth, Kansas, operating an outpatient therapy clinic and supervising as many as fifteen affiliated psychologists and counselors. The first North Hills Administrator testified that his mid-1989 letter promising that North Hills would pay Dr. Jain $1,000 per month for "marketing" was in fact an agreement to pay money for patient referrals. This witness testified that Dr. Jain provided no documentation of any subsequent marketing services; instead, their conversations repeatedly linked the payments to Dr. Jain's substantial volume of patient referrals:

> Q. Can you compare the nature of these conversations with Dr. Jain with your other experience with professionals over the years?
>
> A. Well, it is not unusual for professional people to want to affiliate with hospitals. . . . It is unusual, though, very unusual for a professional person to make it so clear that they are willing to exchange patients for money.
>
> Q. Have you ever had that happen before?
>
> A. Not in such an open manner.
>
> Q. Was there any question in your mind what Dr. Jain was offering in exchange for the hospital to pay money?
>
> A. There was no question at all.

Q. And what was that?

A. Money in exchange for patients.

The next North Hills Administrator testified that Dr. Jain provided little if any tangible marketing support, demanded increased payments, threatened to refer his patients elsewhere if the payments were not increased, and at one time showed the Administrator a letter from a competing hospital offering to pay $2500 for each referral. The payments ceased in October 1990, when a new North Hills Administrator refused to continue the practice.

Dr. Jain testified for the defense. He insisted that North Hills' first Program Director, who did not testify, agreed that North Hills would pay Dr. Jain $100 an hour to provide mental health workshops and other promotional activities in the community. Thus, the letter from the first Administrator did not accurately reflect the understanding. According to Dr. Jain, North Hills persistently under-compensated him for time devoted to these marketing activities, which ultimately led him to terminate the fee arrangement. Dr. Jain directly contradicted the Administrators' testimony. He claimed there was no letter from a competing hospital offering $2500 per patient referral, and he adamantly denied ever requesting money for patient referrals. Indeed, he asserted on direct examination that such conduct would be "stupid," "illegal," "unethical," and "wrong." Nonetheless, the jury obviously believed that he did it.

Between July 1989 and October 1990, North Hills made nineteen payments totaling $40,500 to Dr. Jain, with the payments increasing in amount and frequency during

1990. He referred forty-nine patients to North Hills in 1989 and 1990. One was a Medicare beneficiary. Thirty were insured by the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"), a Defense Department program that provides medical benefits to the spouses and unmarried children of living and deceased members of the military services. The rest were privately insured.

Though the government had strong evidence of a patient referral "kickback" scheme, it had no evidence of tangible harm to Dr. Jain's patients. The government conceded that each patient referred to North Hills was appropriately hospitalized. Several government witnesses testified that North Hills was likely the best acute-care psychiatric hospital in the region. One of Dr. Jain's colleagues, who had no knowledge of the North Hills fee arrangement, testified that he referred patients to North Hills because it was the closest psychiatric hospital to their practice in Leavenworth, because North Hills had a very good staff and program, and because Dr. Jain's clinic had good relations with the staff and easy access to the facility. This psychologist also testified that Dr. Jain "was very professional in his interactions with patients, very caring. He put the patient's well-being as his highest priority." These views were echoed by another government witness, a psychiatrist on the North Hills staff who was also unaware of the fee arrangement. In addition, no witness claimed that any patient received unnecessary care or excessive hospitalization. Thus, there was no proof that any government insurance program suffered a financial loss.

After the jury convicted defendants on all nineteen counts of the indictment, they filed post-trial motions to set aside those convictions. Count One charged a conspiracy to defraud the United States by soliciting kickbacks for referring Medicare and CHAMPUS patients to North Hills. The district court vacated this conviction on the authority of *United States v. Porter,* 591 F.2d 1048 (5th Cir. 1979), and the government does not appeal. Count Three charged Dr. Jain with bribing North Hills officials. The district court vacated this conviction because defendants paid no bribes, and again the government does not appeal. However, the district court upheld the convictions under Count Two, which charged violations of the Medicare anti-kickback statute, 42 U.S.C. § 1320a-7b(b)(1)(A), and counts Four through Nineteen, which alleged a scheme to deprive Dr. Jain's patients of his honest services as a psychologist in violation of the mail fraud statutes, 18 U.S.C. §§ 1341, 1346. The district court sentenced Dr. Jain to five years probation, including six months of home detention, and a $10,000 fine. It imposed special assessments of $850 on Dr. Jain and $3400 on the corporate defendant. Defendants appeal the convictions; the government cross-appeals Dr. Jain's sentence.

II. The Medicare Anti-Kickback Convictions.

Defendants argue that the district court's instructions incorrectly defined the term "willfully" in the Medicare

anti-kickback statute.[1] We will uphold an instruction on the mens rea element of a federal crime if it "fairly and adequately" sets forth the statutory requirement. *United States v. Otto*, 64 F.3d 367, 370 (8th Cir. 1995), *cert. denied*, 133 L. Ed. 2d 879, 116 S. Ct. 956 (1996).

The parties assert radically different positions on this issue of statutory construction. Based upon the traditional principle that ignorance of the law is no defense, the government urges us to apply the general rule that "willfully" in a criminal statute "refers to consciousness of the act but not to consciousness that the act is unlawful." *Cheek v. United States*, 498 U.S. 192, 209, 112 L. Ed. 2d 617, 111 S. Ct. 604 (1991) (Scalia, J., concurring). Defendants urge us to adopt the exception to that general rule that has long been applied in criminal tax cases – willfulness in a criminal tax statute means the "voluntary, intentional violation of a known legal duty." *Cheek*, 498 U.S. at 201. Defendants rely most heavily upon *Ratzlaf v. United States*, 126 L. Ed. 2d 615, 114 S. Ct. 655, 663 (1994), which extended the standard applied in tax cases to criminal prosecutions for "willfully violating" the anti-structuring

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[1] 42 U.S.C. § 1320a-7b provides in relevant part:

(b) Illegal remunerations

(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind –

(A) in return for referring an individual to a person for the furnishing of any item or service for which payment may be made in whole or in part under [Medicare] . . . shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

provisions of the Money Laundering Control Act of 1986, 31 U.S.C. § 5322(a) (1993).

The district court adopted a middle ground. The court declined to instruct the jury that Jain must have intentionally violated a known legal duty because the anti-kickback statute prohibits willful conduct – receiving remuneration for referring patients to a Medicare provider – rather than the willful violation of a statute, as in *Ratzlaf*. But the court also concluded that a mens rea instruction more rigorous than the traditional rule was appropriate because the literal language of this statute might otherwise encompass some types of innocent conduct. Accordingly, modifying language found in 2 Edward J. Devitt, Charles B. Blackmar & Kevin F. O'Malley, FEDERAL JURY PRACTICE AND INSTRUCTIONS, P 30.05 (4th ed. 1990), the court instructed the jury that "the word 'willfully' means unjustifiably and wrongfully, known to be such by the defendant Swaran Jain." It also instructed that "good faith" was a defense to this charge, explaining that Dr. Jain acted in good faith if he believed he was being paid for promoting North Hills, not for referring patients.

We agree with the district court's resolution of this issue. The word "willful" has many meanings and must be construed in light of its statutory context. *Ratzlaf*, 114 S. Ct. at 659. Here, the elements "knowingly and willfully" were added to the statute in 1980[2] to reflect congressional concern "that criminal penalties may be

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[2] See Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, tit. IX, § 917, 94 Stat. 2599, 2625.

imposed under current law to an individual whose conduct, while improper, was inadvertent." H.R. Rep. No. 1167, 96th Cong., 2d Sess. 59 (1980), reprinted in 1980 U.S.C.C.A.N. 5526, 5572. The reference to "inadvertent" is rather ambiguous in this context, since the traditional definition of "willfully" – consciousness of the act – might be sufficient to weed out inadvertent violators. But the statute also has elaborate "safe harbor" provisions, see § 1320a-7b(b)(3), provisions which have prompted pages of administrative agency explication, see 42 C.F.R. § 1001.952. This confirms that a broad "illegal remunerations" statute is like the statute at issue in *Ratzlaf* in that it potentially includes conduct that is not "inevitably nefarious." Only conduct that is inevitably nefarious, that is, "obviously 'evil' or inherently 'bad,'" warrants the traditional presumption that anyone consciously engaging in it has fair warning of a criminal violation. *Ratzlaf*, 114 S. Ct. at 661-62. Thus, we agree with the district court's decision to instruct the jury that the government must meet a heightened mens rea burden. *See Liparota v. United States*, 471 U.S. 419, 423-33, 85 L. Ed. 2d 434, 105 S. Ct. 2084 (1985) (knowingly using food stamp cards in an unauthorized manner requires proof that defendant knew his conduct was unauthorized); *United States v. Curran*, 20 F.3d 560, 569 (3d Cir. 1994); *United States v. Hern*, 926 F.2d 764, 767 & n.6 (8th Cir. 1991).

But that does not mean that the specific instruction adopted in *Ratzlaf* and the criminal tax cases is appropriate in this case. The statute at issue in *Ratzlaf* made criminal a willful violation of another anti-structuring statute. Because one cannot willfully violate a statute without knowing what the statute prohibits, the Supreme

Court required proof that defendant intentionally violated a "known legal duty." See 114 S. Ct. at 658-59. By contrast, in the Medicare anti-kickback statute, the word "willfully" modifies a series of prohibited acts. Both the plain language of that statute, and respect for the traditional principle that ignorance of the law is no defense, suggest that a heightened mens rea standard should only require proof that Dr. Jain knew that his conduct was wrongful, rather than proof that he knew it violated "a known legal duty." Therefore, the district court's definition of "willfully" correctly construed the 1980 amendment to § 1320a-7b. *Hanlester Network v. Shalala*, 51 F.3d 1390, 1399-1400 (9th Cir. 1995), does not persuade us to adopt defendants' position. That case is distinguishable because it involved an administrative debarment proceeding. In addition, the court adopted *Ratzlaf*'s heightened mens rea standard without considering other alternatives to the general rule. Accord *United States v. Neufeld*, 908 F. Supp. 491, 497 (S.D. Ohio 1995).

Alternatively, we conclude that the district court's refusal to give an instruction using the *Ratzlaf* definition of willfully was harmless error. Dr. Jain's defense was that he did not take money from North Hills for referring patients. On direct examination, he testified that payments for patient referrals are not only "unethical" and "wrong," they are "illegal." That testimony effectively took mens rea out of the case, for Dr. Jain acknowledged that, if the jury disbelieved his denials, he would be guilty under his own requested instruction as well as the instruction given by the district court.

III. The Mail Fraud Convictions.

The mail fraud statute prohibits use of the mails to execute "any scheme or artifice to defraud." 18 U.S.C. § 1341. "Essential to a scheme to defraud is fraudulent intent. . . . The scheme to defraud need not have been successful or complete. Therefore, the victims of the scheme need not have been injured. However, the government must show that some actual harm or injury was contemplated by the schemer." *United States v. D'Amato*, 39 F.3d 1249, 1257 (2d Cir. 1994) (citations and quotation omitted). Accord *United States v. Sawyer*, 85 F.3d 713, 725 (1st Cir. 1996). Defendants argue that the government failed to prove a scheme to defraud. We agree.

The government alleged that Dr. Jain's patients were the victims of a fraudulent referral fees scheme. But there was no evidence that any patient suffered tangible harm. So far as the trial record reflects, Dr. Jain provided quality psychological services. Each hospitalized patient required hospitalization. North Hills was as good or better than any alternative facility and provided his patients with proper care. And no patient was financially harmed by Dr. Jain's fee arrangement with North Hills.

The government argues that tangible harm is irrelevant because it proved a scheme to defraud under 18 U.S.C. § 1346, which defines "scheme or artifice to defraud" to include a scheme "to deprive another of the intangible right of honest services." Section 1346 was enacted in 1988 to overrule the Supreme Court's decision in *McNally v. United States*, 483 U.S. 350, 97 L. Ed. 2d 292, 107 S. Ct. 2875 (1987). Though *McNally* and the vast majority of earlier "intangible rights" mail fraud cases

involved corrupt public officials, the government argues that § 1346 encompasses unethical violations of a private professional's fiduciary duty to provide "honest services" to his clients.

It is certainly true that the literal language of § 1346 extends to private sector schemes to defraud another of the right to "honest services." But the transition from public to private sector in this context raises troublesome issues. In a democracy, citizens elect public officials to act for the common good. When official action is corrupted by secret bribes or kickbacks, the essence of the political contract is violated. But in the private sector, most relationships are limited to more concrete matters. When there is no tangible harm to the victim of a private scheme, it is hard to discern what intangible "rights" have been violated. For example, what "honest services" do we expect from a used car salesman, beyond a truthful description of the car being sold? Thus, prior intangible rights convictions involving private sector relationships have almost invariably included proof of actual harm to the victims' tangible interests. In *United States v. Garfinkel*, 29 F.3d 1253, 1258 (8th Cir. 1994), for example, defendant was a University of Minnesota psychiatrist whose scheme deprived a financial sponsor of the valuable benefits of legitimate pharmaceutical research.

Of course, the government limits its argument to undisclosed breaches of a health care professional's fiduciary duty to his clients.[3] But when the client was not

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[3] The regulations of the Kansas Behavioral Sciences Regulatory Board define unprofessional conduct by a licensed

harmed because the breach did not affect the services rendered, how has the client's right to "honest services" been violated? Even in pre-*McNally* cases involving public official misfeasance – decisions whose vitality was restored by § 1346 – we cautioned that "every case of breach of public trust and misfeasance in office in connection with which some mailing has occurred does not and cannot fall within the confines of the mail fraud statute." *United States v. Rabbitt*, 583 F.2d 1014, 1024 (8th Cir. 1978), *cert. denied*, 439 U.S. 1116, 59 L. Ed. 2d 75, 99 S. Ct. 1022 (1979); *see also United States v. McNeive*, 536 F.2d 1245, 1249 (8th Cir. 1976).

Fortunately, this case does not require us to define the outer limits of the private sector rights to "honest services" that are now protected by § 1346. That statute does not stand alone – it modifies the definition of "scheme or artifice to defraud" in § 1341. The essence of a scheme to defraud is an intent to harm the victim. When there has been no actual harm, "the government must produce evidence independent of the alleged scheme to show the defendant's fraudulent intent." *D'Amato*, 39 F.3d at 1257; *see United States v. Pintar*, 630 F.2d 1270, 1279-80 (8th Cir. 1980). Here, all the evidence suggests that Dr. Jain intended to provide and did in fact provide his patients with the highest quality psychological services. While he also extracted undisclosed, unethical referral fees from an interested third party provider, there

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psychologist to include receiving fees for the referral of clients or patients. *See* Kan. Admin. Regs. 102-1-10(b)(20); *see also* American Psychological Ass'n, Ethical Principles of Psychologists and Code of Conduct, Ethical Std. 1.27 (1992).

is no independent evidence proving that he thereby intended to defraud his patients. True, Dr. Jain did not disclose the referral fees, but a fiduciary's nondisclosure must be material to constitute a criminal scheme to defraud. *See United States v. Bronston*, 658 F.2d 920, 927 (2d Cir. 1981), *cert. denied*, 456 U.S. 915, 72 L. Ed. 2d 174, 102 S. Ct. 1769 (1982); *United States v. Brown*, 540 F.2d 364, 375 (8th Cir. 1976). There is simply no evidence that any patient would have considered Dr. Jain's relationship with North Hills material if it did not affect the quality or cost of his services to that patient.

For these reasons, we conclude the mail fraud convictions must be reversed. The government's theory and proof bring to mind our conclusion in an early intangible rights case involving a greedy but uncorrupted public official, *McNeive*, 536 F.2d at 1252:

> The Government here is attempting to criminalize cupidity and we do not believe that § 1341 can be extended to that extreme . . . . There must be, at a minimum, a cognizable scheme to defraud. While we do not place our imprimatur upon McNieve's avariciousness, we fail to find from the Government's proof that McNeive engaged in a scheme to defraud the City of St. Louis of any tangible or intangible right so as to fall within the broad reaches of the mail fraud statute.

IV. The Sentencing Cross-Appeal.

The district court sentenced Dr. Jain for his Medicare anti-kickback offense under U.S.S.G. § 2B4.1, which governs commercial bribery and kickback offenses. That

guideline mandates an increase in the base offense level if an improper benefit exceeding $2000 was conferred upon the defendant. *See* U.S.S.G. §§ 2B4.1(a), (b)(1), and 2C1.1, comment. (backg'd). The amount of the increase is determined by a cross-reference to the table in § 2F1.1. The district court declined to impose an increase because it found that Dr. Jain received less than $2,000 for referring one Medicare patient to North Hills. On appeal, the government argues that all of the $40,500 in referral payments should have been counted as relevant conduct because there was one common scheme or plan.

The district court's factual determination of relevant conduct is reviewed under the clearly erroneous standard. *See United States v. Sheahan*, 31 F.3d 595, 599 (8th Cir. 1994). Relevant conduct for sentencing purposes must be criminal conduct. *Id.* at 600. The district court acquitted Dr. Jain of the bribery charge, and we have acquitted him of the mail fraud charges. At the time in question, Medicare did not reimburse payments for psychologist services, so there is no factual basis to presume that the Jain/North Hills fee arrangement targeted Medicare patients. In these circumstances, while a sentencing court may consider conduct for which the defendant has been acquitted, *see United States v. Galloway*, 976 F.2d 414, 424 n.6 (8th Cir. 1992) (*en banc*), *cert. denied*, 507 U.S. 974, 122 L. Ed. 2d 790, 113 S. Ct. 1420 (1993), we conclude that the district court's findings regarding relevant conduct are not clearly erroneous. *See United States v. Balano*, 8 F.3d 629, 631 (8th Cir. 1993).

The convictions of Dr. Jain and the Center for Mental Health Services, Inc., for violating the Medicare anti-kickback statute, 42 U.S.C. § 1320a-7(b), are affirmed. The

district court's determination of relevant conduct for purposes of sentencing Dr. Jain for that offense is affirmed. Defendants' convictions for violating the federal mail fraud statute are reversed and the cases are therefore remanded for resentencing.

IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

THE UNITED STATES OF AMERICA,	)	
Plaintiff,	)	No. 94-00087-01/ 02-CR-W-6
v.	)	
SWARAN KUMAR JAIN and CENTER FOR MENTAL HEALTH SERVICES, INC.,	)	
Defendants.	)	

MEMORANDUM AND ORDER

Defendants stand convicted of seeking and obtaining referral fees for the hospitalization of mental patients, one of whom was a medicare patient and many of whom were covered by health care offered by the Department of Defense (the CHAMPUS system). Defendant Jain is a psychologist and the corporate defendant is his organization, providing service in the Leavenworth, Kansas, community.

Count One was submitted in the alternative, as a conspiracy to violate the medicare statute prohibiting referral fees (42 U.S.C. § 1320a-7b(b)(1)(A)) or to defraud the United States by interfering with the operation of the CHAMPUS program. Count Two charges willful violation of the medicare statute prohibiting referral fees. Count Three charges bribery of hospital agents by tendering patients to North Hills Hospital in return for referral fees. Counts Four through Nineteen charge mail fraud. As

submitted, the patients were, theoretically, potential victims of the plan to defraud in that taking or soliciting referral fees was allegedly conduct tending to influence Dr. Jain's independent judgment regarding hospitalization of patients.

The payments made, some $40,500, were tendered by the hospital periodically for purported promotional or "marketing" activities which Dr. Jain claims he performed on behalf of the hospital, somewhat surreptitiously, in that he did not publicly identify himself as an agent of the hospital and the payments to him were not disclosed to patients, employees or even to some family members.

The Government's case does not include any proof or contention that patients were inappropriately referred to the hospital. In other words, there was no loss of federal funds shown, and the referral fee system had more potential for harm than actual harm.

Defendants have been vigorously represented, and a considerable number of post-conviction issues have been raised. It now seems clear that I should rule in favor of defendants on the bribery issue, Count Three, and on the major conspiracy to defraud claim (regarding CHAMPUS), under Count One. In other respects, I shall rule for the Government.

1. The Bribery Theory

Count Three, the bribery count, alleges violation of 18 U.S.C. § 666 (a)(2), which forbids corruptly giving something of value to any person, with "intent to

influence . . . an agent of an organization . . . in connection with any business transaction . . . of such organization. . . . " Defendant Jain contends this simply bars bribery in the ordinary sense, where something is given to an agent *personally*, intending to influence or subvert the loyalty of the agent in connection with the transaction of business affairs, in this case, the affairs of the hospital. Since the alleged "bribe," the sending of patients to the hospital itself, did not involve giving "anything of value to any person" (as distinguished from the organization), defendant says the statute was not violated. On further consideration of the issue, I agree with defendant's construction of the statute, particularly in the absence of any citations by the Government contrary to the plain meaning of the statutory language.

Unquestionably the standard meaning of bribery is supplying something of value to an official or agent in order to influence the conduct of that person in a manner contrary to the best interests of the principal. Conflict of interest is implicit in bribery claims. While bribery does connote a "voluntary offer to obtain gain" (*United States v. Adcock*, 558 F.2d 397, 404 (8th Cir. 1977)), it seems invariably to be directed toward influencing conduct of a person having some duty toward another entity. *United States v. Bowles*, 183 F. Supp. 237, 250 (D. Maine 1958) (citing dictionary). It is an assault on integrity (*United States v. Dansker*, 537 F.2d 40, 48 (3rd Cir. 1976)), a subversion of loyalty and judgment (*United States v. Duvall*, 846 F.2d 966, 972 (5th Cir. 1988)). Where there is no conflicting duty of loyalty, as, for example, in paying more than price

controls allow, it is a misnomer to characterize the transaction as bribery. *Anderson Oldsmobile, Inc. v. Hofferbert*, 102 F. Supp. 902, 908 (D. Md. 1952) (Chesnut, D.J.).

In ruling that the Government has failed to establish bribery, in the statutory terms, I do not suggest that defendant Jain may not have been flirting with the criminal law. His conduct, as found by the jury, may have been extortionate (using the *Adcock* theory that "fear of economic loss" can create pressures resulting in extortion – 558 F.2d at 403) or he might have been charged with *soliciting* a bribe (seeking payments which the hospital might believe would influence his conduct toward his patients). Neither the Count Three charge nor the method it was presented allows such a result here. There was a failure of proof as to Count Three and judgment of acquittal will be entered.

2. The Alleged Conspiracy to Defraud CHAMPUS

Defendants have submitted a citation which, in my judgment, defeats the Government's conspiracy case, as it relates to the CHAMPUS patients. In *United States v. Porter*, 591 F.2d 1048 (5th Cir. 1979), a well-reasoned opinion overturned a conviction of doctors who obtained kickbacks from laboratories on medicare testing. The doctors used the laboratories capable of manual testing of blood samples, in preference to those using automated testing at lower cost. The kickback system apparently caused or influenced the choice of laboratories. No financial loss by the Government was claimed, however, and the case had been submitted as a conspiracy which

defrauded the Government of "its right to have the medicare program conducted honestly and fairly." 591 F.2d at 1056. Although an ethical violation was assumed, the case was not prosecuted as a conspiracy to violate federal law, but only as a conspiracy to defraud.

If the interference with the medicare program in *Porter* could not be categorized as fraudulent, I cannot conclude that the interference with the operation of the CHAMPUS program was fraudulent in the sense used in Count One.

Porter has been accepted as sound law, but distinguishable, in *United States v. Barker Steel Co., Inc.*, 985 F.2d 1123, 1130-1 (1st Cir. 1993).[4] See also *United States v. Minarik*, 875 F.2d 1186, 1191 (6th Cir. 1989) (*Porter* applies where there is no "positive obstruction" of a governmental program). The Eighth Circuit decision in *United States v. Anderson*, 579 F.2d 455 (8th Cir. 1978), is also quite different from the case at bar. The jury in *Anderson* was warranted in concluding that there was an "intended effect of defrauding the federal government." 579 F.2d at 458.[5]

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[4] It may be observed that Chief Judge (now Justice) Breyer observed in *Barker Steel* that " 'do good, shun evil' " is not appropriate criminal law statutory wording. 985 F.2d at 1137 (concurring). This seems consistent with the *Porter* ruling that it requires excessive stretching of the conspiracy-to-defraud prohibition to apply it to the sort of misconduct that occurred there, which is reasonably similar in nature to that proved here.

[5] In the present case, apparently unlike *Anderson* but precisely like *Porter*, there was a single ultimate issue of planned misconduct submitted to the jury, the so-called kickback or referral fee agreement. Instruction F, One, b. Although the

Because the conviction on Count One may have been based on the unsound CHAMPUS conspiracy theory rather than the alternate medicare conspiracy theory, it will need to be vacated – presumably for retrial, if desired, or dismissal because it could not result in punishment beyond that allowed by Count Two.

3. Fraud-on-Patients Theory

Counts Four through Nineteen, alleging mail fraud, though pleaded in the alternative, were submitted on a theory that patients were allegedly defrauded. This submission was necessary, in light of my conclusion that *Porter* precludes submission of a theory of defrauding CHAMPUS. Defendants argue, without citation, that common sense precludes a finding of fraud on patients, in the absence of any proof that any patient was hospitalized inappropriately. The Government's response, likewise submitted without citation of authority, simply asserts that fraud is shown because "the payment of money for the referral of patients is improper and interferes with the exercise of independent and unbiased professional judgment owed to patients." (Consolidated Response, page 18).

Somewhat more accurately, the indictment alleges that "the solicitation or receipt of kickbacks . . . *encourages* fraud. . . . " (Consolidated Response, page 10, quoting

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instruction was undesirably wordy, the allegedly illegal plan was sharply focused. The submission was thus narrower than the various possibilities considered in the Report and Recommendation on Motion to Dismiss (Doc. 38), pp. 10-13, and summarized in Government's proposed Instruction 20, One, (c).

from ¶ 11 of the Indictment). We have here, therefore, simply *potential* danger of some tangible injury, that is, subjecting patients to unnecessary hospitalization, and running up unnecessary expenses.

Prior to an amendment to the mail fraud statutes in 1988, the proof in this case would have been insufficient, under *McNally v. United States*, 483 U.S. 350 (1987), requiring proof of a plan to deprive a victim of some property interest. As amended, however, in 18 U.S.C. § 1346, a scheme to defraud may be one to deprive another of the "intangible right of honest services." In the present case, defendants were soliciting and receiving payments from the hospital which the jury concluded were in the nature of referral fees. It may be inferred that such fees were designed to influence Dr. Jain's hospitalization recommendations for patients who were entitled to receive professional advice untainted by selfish interests. The referral fees were conceptually similar to bribes.

Beginning in 1988 it seems fair to refer to bribery as a *per se* violation of the mail fraud statute. *United States v. Mittelstaedt*, 31 F.3d 1208, 1220 (2d Cir. 1994). It is no longer necessary to show financial impact. Perhaps it remains open to defendant Jain to claim the Government must show he "remained bought," and that his thought processes were actually influenced by the availability of referral fees. Such a construction would, however, defeat the purpose of the 1988 amendment, except in rare cases where there may be admissions regarding a defendant's thoughts, or express promises that payments will produce certain results.

In the present case, where Dr. Jain denied receiving money in the nature of referral fees, I believe the jury was entitled to conclude not only that referral fees were received but that their solicitation and receipt was pursuant to a plan to create a conflict of interest, thus depriving patients of the "the intangible right of honest services," even though tangible losses cannot be established.

The motions for judgments of acquittal on Counts Four through Nineteen will therefore be denied.

4. Other Issues

Defendants present additional post-trial issues that have been considered, but in my judgment require no analysis in this ruling. Mention will be made, however, of the defendants' contention that knowledge of *illegality* must be found by the jury in all instances in this case where willfulness is at issue. These include the referral fee conspiracy charged in Count One, and in the medicare referral fee charge in Count Two. The instruction on willfulness, M, requires only that defendant Jain acted "unjustifiably and wrongfully" in taking prohibited referral fees, and knew that his conduct should be so characterized.[6]

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[6] Willfulness in that sense was adequately established by the testimony of Dr. Jain and his brother, on the hypothesis, challenged by Dr. Jain, that his financial arrangements amounted to taking referral fees.

The case on which defendants principally rely, *Ratzlaf v. United States*, 114 S. Ct. 655 (1994), must, in my judgment, be confined to its own context, the "structuring" of cash deposits to avoid reporting requirements. The *Ratzlaff* opinion accepts the proposition that willfulness is a " 'word of many meanings,' " even though it sometimes requires knowledge of unlawfulness. The majority opinion notes that structuring of financial transactions is so frequently done legitimately, simply to avoid undesired consequences, so that it should be treated as innocent conduct, absent knowledge of a legal prohibition. It will not be presumed that Congress intended to leave to juries whether ordinary tax avoidance, for example, should be treated as somehow wrongful. It is perhaps arguable that referral fees are so commonly untainted that Congress must be presumed to have intended that the Government prove knowledge of illegality. I doubt the soundness of that view, and believe financial structuring to be unlike referral fees, as a general proposition.

If I was correct in rejecting the special scienter requirement urged by defendants, I do not understand that they challenge the wording of Instruction No. M, which imposes a serious burden of proof on the Government. It may be worth noting, however, that the instruction was somewhat jerry-built, using the terminology of "unjustifiable" and "wrongful" appearing in ¶ 30.05 of Devitt, Blackmar and O'Malley, *Federal Jury Practice and Instructions*, vol. 2, Fourth Edition, while stiffening the terminology to change a disjunctive to a conjunctive, and adding the requirement of knowledge of the improper aspect of the transaction. It is my recollection that neither party objected to the wording, if *Ratzlaf* does not apply.

It may also be mentioned, for appellate understanding, that the parties did not ask instruction on a matter dealt with in testimony, whether referral fees are prohibited by Department of Defense regulations. The jury did inquire on that issue, and no advice was given with respect to the Government's theory of regulation violation. If pressed, I probably would have expressed an opinion that the regulations do not prohibit referral fees, at least in the absence of proof of unnecessary referrals, based on my understanding of the regulatory wording.[7]

The debatable violation of regulations was immaterial, because defendant Jain conceded that such fee arrangements would be "unjustifiable" and "wrongful" as a matter of professional ethics, and therefore, in my opinion, qualifying for willful misconduct, prohibited by statute, under Count Two. It is therefore

ORDERED that a judgment of acquittal be entered on count Three, that the conviction on Count one be vacated,

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[7] Referral fee arrangements doubtless present a serious potential for fraudulent overcharges to the CHAMPUS system, and there was an aspect of deceptive concealment of referral fees in this case, but the Government argues that all referral fees, whether or not disclosed and whether or not financially harmful to the Government, are deemed fraudulent under 32 CFR §§ 199.2(b) or 199.9(c)(12) or (13). I cannot satisfy myself that this is so.

and that the defendants' post-trial motions be otherwise denied.[8]

/s/
HOWARD F. SACHS
SENIOR DISTRICT JUDGE

Dated: January 9, 1995

[8] Sentencing will be scheduled on Counts Two and Four through Nineteen.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 95-2820WMKC

United States of America, Appellee/Cross-Appellant, vs. Swaran Kumar Jain, et al., Appellants/Cross-Appellees	)	Appeal from the United States District Court for the Western District of Missouri

Appellants/cross-appellees' petition for rehearing has been considered by the court and is denied.

Appellee/cross-appellant's petition for rehearing, although received untimely, will be accepted and filed. The petition has been considered by the court and is denied on the merits.

October 22, 1996

Order Entered at the Direction of the Court:

/s/ Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit

UNITED STATES CODE ANNOTATED, TITLE 42 "THE PUBLIC HEALTH AND WELFARE"

§ 1320a-7b. Criminal penalties for acts involving Medicare or State health care programs

(a) Making or causing to be made false statements or representations

Whoever –

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a-7(h) of this title),

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such

benefit or payment or any part thereof to a use other than for the use and benefit of such other person, or

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a program under subchapter XVIII of this chapter or a State health care program and knows that the individual who furnished the service was not licensed as a physician, shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under subchapter XIX of this chapter is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of that subchapter or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) Illegal remunerations

(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind –

> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program, or
>
> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person –

> (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to –

(A) a discount or other reduction in price obtained by a provider of services or other entity under subchapter XVIII of this chapter or a State health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider, or entity under subchapter XVIII of this chapter or a State health care program;

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;

(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under subchapter XVIII of this chapter or a State health care program if –

(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a

fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

(ii) in the case of an entity that is a provider of services (as defined in section 1395x(u) of this title), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

(D) a waiver of any coinsurance under part B of subchapter XVIII of this chapter by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act [42 U.S.C.A. § 201 et seq.]; and

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987.

(c) False statements or representations with respect to condition or operation of institutions

Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, rural primary care

hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter or a State health care program, or with respect to information required to be provided under section 1320a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Illegal patient admittance and retention practices

Whoever knowingly and willfully –

(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient) –

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(e) Violation of assignment terms

Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u(h)(1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.